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FISCAL IMPACT STATEMENT

LS 7267

BILL NUMBER: SB 540

NOTE PREPARED: Jan 30, 2013

BILL AMENDED:

SUBJECT: Implementation of Federal Affordable Care Act.

FIRST AUTHOR: Sen. Tallian

BILL STATUS: As Introduced

FIRST SPONSOR:

FUNDS AFFECTED: X GENERAL
X DEDICATED
X FEDERAL

IMPACT: State & Local

Summary of Legislation: This bill requires the Department of Insurance (DOI) to create a health insurance exchange (HIX) in Indiana.

The bill establishes the Indiana Affordable Care Study Committee to study and make recommendations to the Legislative Council concerning the establishment and implementation of a health benefit exchange in Indiana and the defining of "essential health benefits" for use in Indiana. The bill requires the DOI to report annually to the study committee concerning the status and operation of the health benefit exchange established by the DOI.

The bill changes Medicaid eligibility requirements as allowed under the federal Patient Protection and Affordable Care Act.

The bill expires, on December 31, 2013, language that sets forth certain asset limitations within the Medicaid program.

The bill also requires the Legislative Services Agency to prepare legislation for introduction in the 2014 session to make necessary changes to statutes affected by this act.

Effective Date: Upon passage; July 1, 2013.

Summary of NET State Impact: *Affordable Care Study Committee:* The establishment of the Affordable

Care Study Committee is expected to annually cost up to \$9,500, assuming the Legislative Council continues to fund study committees at the same level as in the 2012 interim session.

Medicaid Expansion to 138% Federal Poverty Level (FPL): According to projections prepared by the Medicaid actuary, the state could cover an additional 427,000 individuals under the Medicaid program for \$66.6 M in FY 2014, and \$106.6 M in FY 2015, leveraging an additional \$3.953 B in federal funds for the biennium. Because the ACA provides for diminishing federal matching funds for the expansion populations over time, the longer a state would wait to expand Medicaid eligibility, the more expensive it would become to implement after CY 2016.

An indeterminate level of possible state savings related only to an expansion of Medicaid for low-income childless adults may be realized in decreased state subsidies for a variety of mental health, health, and health screening services. Increased savings from inpatient acute care services provided to residents of state institutions including correctional facilities may also be possible provided certain administrative changes would be made.

Expiration of Asset Limitations: The fiscal impact of the expiration of asset limitations for the aged, blind, and disabled eligibility group is linked to the conversion of the state to 1634 status. This conversion is included as one of the assumptions used to develop the Medicaid actuary contractor's analysis of the Medicaid expansion to 138% FPL.

Health Insurance Exchange: The fiscal impact of this bill will depend on (1) when a state-operated health insurance exchange blueprint would be submitted and approved, (2) when the exchange would be operational and coverage effective, and (3) how ongoing operational costs would be provided.

Explanation of State Expenditures: *Affordable Care Study Committee:* The bill establishes the 14-member Affordable Care Study Committee consisting of 8 legislators, 3 lay members, and 3 state employees. The committee is to operate under the policies governing study committees adopted by the Legislative Council. Legislative Council resolutions in the past have established budgets for interim study committees in the amount of \$9,500 per interim for committees with fewer than 16 members. The Committee is to study and make recommendations concerning the establishment of a HIX in Indiana, and the definition of Essential Health Benefits for use in the state. The committee is also to receive and consider annual reports from the DOI concerning the status and operation of the HIX required to be established by DOI under provisions of the bill.

Medicaid Expansion to 138% FPL. This analysis is based on the September 18, 2012, "ACA - Medicaid Financial Impact Analysis" prepared by Milliman, the state's Medicaid actuary contractor. It is assumed that ACA-required expenses unrelated to any expansion of eligibility as projected by Milliman (Scenario 1) are included in the Medicaid forecasted expenditures for the purposes of the budget. It is further assumed that the cost of the full expansion will be the scenario using the Milliman projected participation rates (Scenario 3) since the analysis specifically states that it should not be expected that the full participation projected in Scenario 4, will occur. The incremental cost to the state of an expansion of Medicaid eligibility on January 1, 2014, to 138% of FPL was estimated by Milliman as shown below.

Expansion to 138% FPL	FY 2014	FY 2015	FY 2016	FY 2017
Incremental State Dollars	\$ 66.6 M	\$ 106.6 M	\$ 103.8 M	\$ 175.2 M
Incremental Federal Dollars	\$ 1,286.3 M	\$ 2,666.7 M	\$ 2,792.2 M	\$ 2,856.7 M
Total Incremental Expenditures	\$ 1,352.9 M	\$ 2,773.3 M	\$ 2,896.7 M	\$ 3,031.9 M

The Milliman enrollment analysis for FY 2015, projects the total Medicaid/ CHIP population to be 1,205,000 with no expansion. Expansion to 138% FPL is estimated to provide coverage to an additional 427,000 individuals for a total enrollment of 1,632,000.

Medicaid is jointly funded by the state and federal governments. The effective state share of program expenditures is approximately 33% for most current services. Current Medicaid medical services are matched by the effective federal match rate (FMAP) in Indiana at approximately 67%. Administrative expenditures with certain exceptions are matched at the federal rate of 50%. Under provisions of the ACA, the enhanced FMAP for the expansion population will be:

- (1) 100% for CY 2014, 2015, and 2016;
- (2) 95% in CY 2017;
- (3) 94% in CY 2018;
- (4) 93% in CY 2019; and
- (5) 90% in CY 2020 and thereafter.

The longer a state waits to expand Medicaid eligibility to 138% FPL, the more expensive it will become to implement after CY 2016. The federal Department of Health & Human Services (DHHS) has specified that the ACA enhanced FMAP for expansion populations is only available in the circumstance of a full expansion; partially expanding the Medicaid-eligible population to a lower FPL income standard would qualify only for the state's normal FMAP percentage.

Expiration of Asset Limitations: The fiscal impact of the expiration of asset limitations for the aged, blind and disabled eligibility group is linked to the conversion of the state to 1634 disability determination status. This conversion is included as an assumption used to develop the Medicaid actuary contractor's analysis of the Medicaid expansion to 138% FPL. [See the discussion under *Medicaid Expansion to 138% FPL*.]

Expansion Population: Department of Corrections (DOC) and Family and Social Services Administration (FSSA): The fiscal impact of a Medicaid expansion on DOC and FSSA medical expenditures would be expected to produce some level of savings. However, there are no data available at this time regarding the extent of acute inpatient care paid for residents of state facilities. The State Budget Agency currently administers an annual General Fund appropriation of \$25 M specifically for payment for medically necessary services provided outside the institutions. The extent to which these services include inpatient services would determine the potential level of savings available. Initial savings may be offset by administrative expenses necessary for the Office of Medicaid Policy and Planning (OMPP) to implement a program and coordinate with the affected agencies.

Health Insurance Exchange: No matter what government entity, federal or state, operates the HIX, the state will have initial expenses associated with integrating IT systems and coordinating state agency operations with an exchange as required by the ACA. Federal grants and Medicaid administrative expenditures (matched with 50% federal funds) are anticipated to be the source of the required funding. It is assumed that expenses for

these activities are included in the budgets submitted by the affected agencies.

HIX Development: Federal regulations provide that if a state elects to seek approval of a HIX after January 1, 2013, the state must have in effect an approved or conditionally approved Exchange Blueprint and an operational readiness assessment at least 12 months prior to the HIX's first effective date of coverage. Additionally, since Indiana will initially have a federally facilitated HIX, a plan must be developed jointly with HHS to transition from the federal HIX to a state HIX. The bill is effective upon passage. Federal grant funds for the development of a HIX are available to states until October 15, 2014 - the last date to apply for these grant funds. Assuming that Indiana would apply for and receive a federal HIX development grant prior to the October 15, 2014, cut-off date, there would be no state expense involved in developing the state-operated HIX.

HIX Operating Costs: The operation of a state HIX in Indiana has been estimated to annually cost between \$34.3 M to \$64.2 M. The wide range in the cost projection is explained by uncertainty with regard to the responsibility for the cost of determining eligibility for the federal advanced-payment tax credit (APTC). If the state is responsible for the APTC eligibility determination, costs are expected to be higher; if the federal government makes the APTC determination, the state costs would be lower. [For comparative purposes, the Massachusetts Connector, the model for state-operated HIX, is budgeting \$42 M for operations in 2013; the Minnesota HIX is estimating first-year operating costs of \$54 M with \$13 M of that coming from Medicaid administrative dollars.] Assuming that DOI and FSSA could have an Exchange Blueprint prepared, submitted, and approved by July 1, 2013, a state-operated HIX could potentially have a coverage effective date of July 1, 2014.

Additional Information

Medicaid Expansion: The Milliman analysis excluded the college and graduate student population because the data indicated they may not have been appropriately grouped with their parents, causing an inappropriate match between income level and insurance coverage. The exclusion of this group may cause the expansion costs to move towards the maximum exposure cost range included in the analysis. Connecticut, a state that chose to expand the low-income population early, found that families have dropped insurance coverage for their college students when they determined they could be covered at no cost under Medicaid. Connecticut has requested a waiver from the Centers for Medicare and Medicaid Services (CMS) that would allow students claimed as dependents for purposes of a parent's income tax liability be excluded from Medicaid coverage.

Expansion Populations - DOC and FSSA: Currently, the Medicaid Act provides an exception to the inmate prohibition for federal matching funds when a resident or inmate becomes an inpatient in a medical institution. CMS has clarified that federal matching funds would be available when a resident or inmate is admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility, or ICF-MR, provided that they meet any additional criteria for the services such as income eligibility or level-of-care requirements for long-term care. Current Indiana Medicaid eligibility is not available generally to nondisabled adults without dependent children. If Indiana Medicaid would be expanded under the Affordable Care Act to include adults under the age of 65 with income below 138% of the federal poverty level, this exception might provide for the possibility to realize increased savings on medical expenses incurred for residents of state-run institutions and inmates of correctional facilities. The inmate exception could also result in some savings with regard to inmates or residents that are currently eligible for Medicaid who require inpatient services; an example would be inpatient labor and delivery services for pregnant women. The level of savings available would depend on the extent of services currently provided that could qualify for Medicaid federal financial participation and the expansion

of the Medicaid population.

HIX Planning Grants: FSSA received two federal planning grants to perform work required to plan for the implementation of a HIX. Since no decision was made at the time, the FSSA and the Department of Insurance (DOI) investigated actions that would be needed to implement a state-run HIX, a state/federal partnership HIX, or a federally facilitated HIX.

Explanation of State Revenues: *Medicaid Expansion to 138% FPL.* [See *Explanation of State Expenditures* for the discussion of federal Medicaid matching funds.]

Health Insurance Exchange: Depending on legislative and administrative decisions, this bill could increase revenue the state receives from (1) federal funds provided to states that implement state-operated health exchanges, (2) grant funding available under Section 1311 of the ACA for state expenses of administering a state-operated HIX, and (3) monthly user fees paid by individuals who obtain insurance products from a state-operated HIX, or fees on insurers selling products on a HIX.

HIX Operating Revenue: Under provisions of the ACA, the first year of HIX operations are to be provided by the federal government. However, the year was defined to end on January 1, 2015, after which state-operated exchanges must achieve self-sustainability. [The Massachusetts Connector, the model for the HIX, is supported by an assessment on the insurance products sold on the exchange. The federally facilitated exchanges will also be assessing a 3.5% user fee to support the operations of the federal HIX operated in states that do not establish an exchange.] Assuming that DOI and FSSA could have an Exchange Blueprint prepared, submitted, and approved by July 1, 2013, a state-operated HIX could potentially have a coverage effective date of July 1, 2014. Under that assumption, Indiana could potentially still qualify for 6 months of operating support before the state would need to either provide funds or implement user fees to support the operation of the HIX. The state could also choose to assess user fees immediately since Indiana would be transitioning from a federally facilitated exchange. [HHS has indicated the federally facilitated exchanges will charge a user fee.] The size of the fee would depend on the costs to be covered and the number of HIX users. The source of ongoing operational funding for a state-operated HIX will ultimately be determined by the General Assembly.

Explanation of Local Expenditures: *Medicaid Expansion to 138% FPL and Township Trustees:* Expansion of Medicaid to the low-income adult population could result in savings to townships and counties by virtue of providing Medicaid coverage for the adult population that would be newly eligible for coverage. In CY 2011, township trustees provided just over \$1 M in healthcare expenditures from township sources. There are no data to indicate whether expenditures were for services or products that would have been covered by Medicaid or if the individuals on behalf of whom expenditures were made would have been eligible for Medicaid under the required ACA expansion.

Explanation of Local Revenues:

State Agencies Affected: DOI; DOC; State Department of Health; FSSA.

Local Agencies Affected: Township trustees.

Information Sources: CMS; Christina Hage, FSSA; FSSA Presentation to Joint Insurance and Health Finance Commission meeting from September 19, 2012; FSSA Presentation to the State Budget Committee, December 12, 2012; “ACA - Medicaid Financial Impact Analysis”, Milliman, September 18,

2012; Minnesota HIX operating projections at
http://www.twincities.com/politics/ci_22012154/minnesota-health-exchange-cost-54-million-operate;
Massachusetts Connector, Board of Director's Meeting July 2012, 2013 Budget at
www.MAHealthconnector.org. "Township Assistance Report, 2011", DLGF Data Base; Wall Street
Journal, July 1, 2012, " Connecticut Seeks to Tighten Medicaid Eligibility".

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